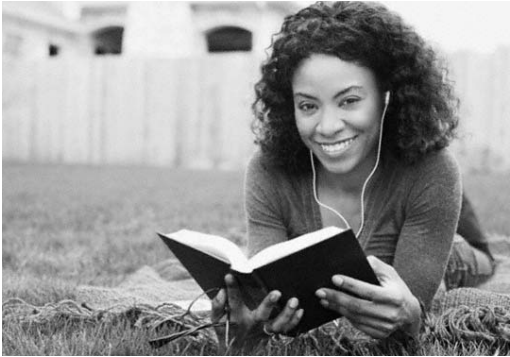


| Dental Plans Comparison Chart | | | | | |
|----------------------------------|---|---|---|---|---|
| | SAFEGUARD | DELTACARE | DELTA DENTAL PLAN | | |
| | | | DELTA PREFERRED OPTION (DPO) | IN-NETWORK | OUT-OF-NETWORK |
| Type of Plan | An HMO-style dental plan | An HMO-style dental plan | A dental plan that offers two provider networks and out-of-network benefits | | |
| Annual Deductible | None | None | None | \$50/person; \$150/family | \$50/person; \$150/family |
| Annual Maximum Benefit | None | None | \$1,750/person | \$1,750/person | \$1,750/person |
| COVERED SERVICES PREVENTIVE CARE | | | | | |
| Cleaning | 100% (two every 12 months) | 100% (two every 12 months) | 100% (two/calendar year) | 85% of covered charges (no deductible on first two cleanings/calendar year) | 85% of R&C (no deductible on first two cleanings/calendar year) |
| Exam | 100% | 100% | 100% (two/calendar year) | 85% of covered charges (two/calendar year) | 85% of R&C (two/calendar year) |
| Full Mouth X-Rays | 100% (one every 24 months) | 100% (one every 24 months) | 100% (one every five years) | 85% of covered charges (one every five years) | 85% of R&C (one every five years) |
| BASIC SERVICES | | | | | |
| Emergency Treatment | \$5 copay | \$5 copay | 100% of covered charges | 85% of covered charges | 85% of R&C |
| Extractions | 100% (except \$50 copay for bony impactions) | 100% (except \$50 copay for bony impactions) | 85% of covered charges | 85% of covered charges | 85% of R&C |
| Fillings | 100% | 100% | 85% of covered charges | 85% of covered charges | 85% of R&C |
| General Anesthesia | \$30 copay for medically necessary extractions only | \$30 copay for medically necessary extractions only | 85% of covered charges for oral surgery only | 85% of covered charges for oral surgery only | 85% of R&C for oral surgery only |
| Gingivectomy | \$55 copay/quadrant | \$55 copay/quadrant | 85% of covered charges | 85% of covered charges | 85% of R&C |
| Root Canals | \$45 copay/canal | \$45 copay/canal | 85% of covered charges | 85% of covered charges | 85% of R&C |
| MAJOR SERVICES | | | | | |
| Bridges | \$60 copay/unit | \$60 copay/unit | 50% (once every five years) | 50% (once every five years) | 50% of R&C (once every five years) |
| Crowns | \$60 copay/crown | \$60 copay/crown | 85% (once every five years) | 85% (once every five years) | 85% of R&C (once every five years) |
| Dentures | \$70 copay/complete upper or lower denture | \$70 copay/denture | 50% (once every five years) | 50% (once every five years) | 50% of R&C (once every five years) |
| Orthodontia | \$1,000 copay + \$150 start-up fees | \$1,150 copay + \$350 start-up fees | 50% (\$1,200 lifetime maximum) | 50% (\$1,200 lifetime maximum) | 50% (\$1,200 lifetime maximum) |
| TMJ | Not covered | Not covered | Not covered | Not covered | Not covered |

| Contact Information | | |
|--|--------------|---------------------------|
| Contact | Phone Number | Web Site |
| COUNTY DEPARTMENT OF HUMAN RESOURCES | | |
| Benefits Hotline | 213-388-9982 | N/A |
| Web site | N/A | http://dhr.lacounty.info/ |
| BENEFITS SYSTEM | | |
| Web enrollment | N/A | mylacountybenefits.com |
| Telephone enrollment | 888-822-0487 | N/A |
| Fax | 310-788-8775 | N/A |
| MEDICAL | | |
| PacifiCare HMO | 800-367-2660 | healthatcola.com |
| UnitedHealthcare Choice Plus PPO (formerly PacifiCare PPO) | 800-367-2660 | healthatcola.com |
| Kaiser Permanente | 800-464-4000 | my.kp.org/ca/countyofla |
| DENTAL | | |
| SafeGuard | 800-880-1800 | www.safeguard.net |
| DeltaCare | 800-422-4234 | deltadentalins.com |
| Delta Dental | 888-335-8227 | deltadentalins.com |
| FLEXIBLE SPENDING ACCOUNTS | | |
| Administrator (Ceridian) | 866-300-2303 | mylacountybenefits.com |
| Fax | 888-367-3305 | N/A |
| LIFE AND AD&D | | |
| CIGNA Life | 800-842-6635 | cigna.com |

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options



2010 Annual Benefits Medical and Dental Plans Comparison Chart

What’s Changing in 2010*

Your *Options* plan choices are not changing for 2010. However, due to continued increases in the cost of health care, monthly premiums for medical plans will increase next year.

The **PacifiCare PPO** has a new name for 2010. It will now be called the **UnitedHealthcare Choice Plus PPO**. (UnitedHealthcare purchased PacifiCare in 2005.) Other than receiving a new company name on your membership card, very little will change for PPO plan members. You will still have access to all PacifiCare PPO doctors, mental health clinicians and hospitals, as well as gaining access to the entire UnitedHealthcare national network. The major changes will be to prescription drug benefits:

- In some cases you’ll pay less for self-injectable drugs (you’ll pay a fixed prescription plan copay rather than a coinsurance percentage)
- Fewer drugs will require plan pre-approval to be covered.

UnitedHealthcare Choice Plus PPO will raise the lifetime coverage maximum to \$5 million from \$2 million.

Mental health and substance abuse benefits have been enhanced for all plans to comply with the Mental Health Parity Act.

Optional group term life, dependent term life and accidental death and dismemberment insurance rates will decrease.

** Benefit plans and premium rate changes are subject to final approval by the Board of Supervisors.*

2010 Options Annual Benefits Medical and Dental Plans Comparison Chart



| Medical Plans Comparison Chart | | | | |
|--------------------------------|---|--|---|--|
| | KAISER | PACIFICARE HMO | UNITEDHEALTHCARE CHOICE PLUS PPO (FORMERLY PACIFICARE PPO) | |
| | | | IN-NETWORK | OUT-OF-NETWORK |
| Type of Plan | A group model HMO with its own hospitals, outpatient facilities, staff physicians, nurses and other health care professionals | An HMO that contracts with private hospitals, medical groups and individual private practice physicians for services at negotiated rates | A medical plan that allows you to choose an in-network PPO provider or an out-of-network provider each time you need care | |
| Annual Deductible | None | None | \$300/person \$1,500/family | \$1,500/person \$3,000/family |
| Annual Out-of-Pocket Maximum | \$1,500/person \$3,000/family | \$1,000/person \$2,000/family | \$5,000/person \$15,000/family | \$15,000/person \$45,000/family |
| | | | Excludes deductible/combined in- and out-of-network | |
| Lifetime Maximum Benefit | Unlimited | Unlimited | \$5,000,000 (combined) | |
| PREVENTIVE CARE | | | PREVENTIVE CARE | |
| Immunizations | No charge | No charge | No charge | No charge for covered amounts |
| Periodic Health Evaluations | No charge | No charge | No charge | No charge for covered amounts |
| MEDICALLY NECESSARY CARE | | | MEDICALLY NECESSARY CARE | |
| Ambulance | No charge if medically necessary | No charge if medically necessary | 20% copay after deductible | 20% copay after deductible |
| Doctor Office Visit | \$10 copay/visit; no charge pediatric visit to age 5 | \$10 copay/visit; no charge pediatric visit to age 5 | 20% copay, no deductible | 50% copay after deductible |
| Emergency Room | \$50 copay; waived if admitted (see plan booklet for a description of emergency services) | \$50 copay (waived if admitted) | 20% copay after deductible (waived if admitted) | 50% copay after deductible (waived if admitted) |
| Hospital Care | No charge | No charge | 20% copay after deductible | 50% copay after deductible |
| Maternity | \$10 copay for office visit to confirm pregnancy; no charge thereafter | No charge | 20% copay after deductible | 50% copay after deductible |
| Surgery | Inpatient: No charge Outpatient: \$10 copay | No charge | 20% copay after deductible | 50% copay after deductible |
| X-Ray & Lab Tests | No charge | No charge | 20% copay, no deductible | 50% copay after deductible |
| Prescription Drugs | \$5 copay generic and \$20 copay brand name for up to 100-day supply for each medication prescribed by a Kaiser physician or any dentist and filled at a Kaiser pharmacy Sexual dysfunction drugs: 50% copay (limitations apply) | Pharmacy: \$5 copay generic; \$20 copay brand name (30-day supply). Mail order: \$10 copay generic; \$40 copay brand name (90-day supply) Sexual dysfunction drugs: 50% copay (limitations apply) | Pharmacy: \$5 copay Tier 1; \$20 copay Tier 2; \$35 copay Tier 3 (30-day supply). Mail order: \$10 copay Tier 1; \$40 copay Tier 2; \$70 copay Tier 3 (90-day supply). Sexual dysfunction drugs: 50% copay (limitations apply) | Not covered |
| MENTAL HEALTH CARE | | | MENTAL HEALTH CARE | |
| Hospital Inpatient Care | No charge | No charge | 20% copay after deductible | 50% copay after deductible |
| Hospital Outpatient Care | \$10 copay/visit | \$10 copay/visit | 20% copay after deductible for covered charges | 50% copay after deductible for covered charges |
| OTHER PLAN BENEFITS | | | OTHER PLAN BENEFITS | |
| Home Health Care | No charge within Kaiser area (up to 2 hours/visit; 3 visits/day; 100 visits/calendar year) | \$10 copay | 20% copay/visit after deductible, preauthorization required | 50% copay after deductible, preauthorization required |
| | | | (up to 100 visits/calendar year; combined in- and out-of-network) | |
| Hospice Care | No charge | No charge | 20% copay after deductible | 50% copay after deductible |
| Physical Therapy | \$10 copay/visit | \$10 copay/visit | 20% copay/visit, no deductible (up to 40 visits each for physical/speech/cardio therapy; combined inpatient and outpatient) | 50% copay after deductible |
| Skilled Nursing Facility | No charge (up to 100 days/benefit period) | No charge (up to 100 days/condition) | 20% copay after deductible | 50% copay after deductible |
| | | | (up to 40 non-consecutive days/condition; combined in- and out-of-network) | |
| Vision Care | No charge for refraction exam; does not cover glasses | \$10 copay for eye exam (1 every 12 months) \$10 copay for lenses and frames (1 pair every 24 months) | \$10 copay for eye exam (1 every 12 months) \$10 copay for lenses & frames (1 pair every 24 months), no deductible | Coverage limited to reimbursement provided under VSP out-of-network schedule |

Indicates Plan Changes

This is not an official summary plan description (SPD) or official plan document. If you need a copy of an official plan document, contact the plan's Customer Service department directly. If there is a difference between what you read in this comparison chart and what you read in an official plan document, the official plan document will rule.